AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

I authorize the use and disclosure of my Protected Health Information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name | **Last Name**

Street Address | **City, State, Zip**

IS Number | **Birth Date** | **( ) Phone Number**

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Los Angeles County Department of Mental Health (LACDMH) and/or Brilliant Corners to use, receive, share, and/or disclose my PHI, as described below, to property owners; property management companies; and/or vendors of appliances, furniture, and/or other household goods in order to assist homeless individuals with move-in assistance such as security deposits, household goods, eviction prevention, ongoing rental assistance, utility assistance and minor rehabilitative repairs funded by LACDMH.

REDISCLOSURE NOTICE:

I understand that my PHI that is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Used, Received and/or Disclosed:

Information contained in the Housing Assistance Program – Universal Application such as acknowledgment of currently receiving mental health services, verification of other medical conditions or co-occurring disorders, demographics, income, current address, social security number, employment information, the length of homelessness, and any additional information that would assist an individual/family applying for move in assistance funds under the Housing Assistance Program. In addition, any information required for data collection, program evaluation and/or monitoring such as program affiliation, homeless verification, demographics, use of funds, duration of housing stay, income, and frequency, type and financial value of mental health services.

Purpose of Disclosure:

My PHI may be used to determine eligibility and implementation of the LACDMH funded Housing Assistance Program administered by Brilliant Corners for security deposits, assistance with locating and/or maintain permanent housing, advocacy and/or program implementation with property owners or property management companies and compliance with data collection and monitoring/evaluation requirements of the program.

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION
HOUSING ASSISTANCE PROGRAM
COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

N O T I C E

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. *LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

EXPIRATION DATE

Expiration Date: This authorization remains valid until the individual or family has vacated the unit that a security deposit or ongoing rental assistance was paid on their behalf, and/or indicated complete satisfaction with any household goods or other services purchased on their behalf under the Housing Assistance Program.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to **LACDMH Countywide Housing, Employment, and Education Resource Development - Housing Policy and Development Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005**. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative **Date**

If signed by other than client, state relationship and authority to do so: